

practitioner, 89-certified clinical nurse, or 97-physician assistant.

(B) At least 60 percent of the practitioner's allowed charges under the physician fee schedule (excluding hospital inpatient care and emergency department visits) during a reference period specified by the Secretary are for primary care services.

Primary care services means—

(i) New and established patient office or other outpatient evaluation and management (E/M) visits;

(ii) Initial, subsequent, discharge, and other nursing facility E/M services;

(iii) New and established patient domiciliary, rest home (for example, boarding home), or custodial care E/M services;

(iv) Domiciliary, rest home (for example, assisted living facility), or home care plan oversight services; and

(v) New and established patient home E/M visits.

(b) *Payment*. (1) For primary care services furnished by an eligible primary care practitioner on or after January 1, 2011 and before January 1, 2016, payment is made on a quarterly basis in an amount equal to 10 percent of the payment amount for the primary care services under Part B, in addition to the amount the primary care practitioner would otherwise be paid for the primary care services under Part B.

(2) The payment described in paragraph (b)(1) of this section is made to the eligible primary care practitioner or, where the physician has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

[75 FR 73617, Nov. 29, 2010]

§ 414.90 Physician Quality Reporting System (PQRS).

(a) *Basis and scope*. This section implements the following provisions of the Act:

(1) 1848(a)—Payment Based on Fee Schedule.

(2) 1848(k)—Quality Reporting System.

(3) 1848(m)—Incentive Payments for Quality Reporting.

(b) *Definitions*. As used in this section, unless otherwise indicated—

Administrative claims means a reporting mechanism under which an eligible professional or group practice uses claims to report data on PQRS quality measures. Under this reporting mechanism, CMS analyzes claims data to determine which measures an eligible professional or group practice reports.

Certified survey vendor means a vendor that is certified by CMS for a particular program year to transmit survey measures data to CMS.

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule as provided under section 1848(k)(3) of the Act and which are furnished by an eligible professional.

Direct electronic health record (EHR) product means an electronic health record vendor's product and version that submits data on PQRS measures directly to CMS.

Electronic health record (EHR) data submission vendor product means an entity that receives and transmits data on PQRS measures from an EHR product to CMS.

Eligible professional means any of the following:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(l)(3)(B) of the Act).

Group practice means a physician group practice that is defined by a TIN, with 2 or more individual eligible professionals (or, as identified by NPIs) that has reassigned their billing rights to the TIN.

Group practice reporting option (GPRO) web interface means a web product developed by CMS that is used by group practices that are selected to participate in the group practice reporting option (GPRO) to submit data on PQRS quality measures.

Maintenance of Certification Program means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification Program or an equivalent program (as determined by

the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism. Such a program must include the following:

- (i) The program requires the physician to maintain a valid unrestricted license in the United States.
- (ii) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.
- (iii) The program requires a physician to demonstrate, through a formalized secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.
- (iv) The program requires successful completion of a qualified maintenance of certification program practice assessment.

Maintenance of Certification Program Practice Assessment means an assessment of a physician's practice that—

- (i) Includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine.
- (ii) Includes a survey of patient experience with care.
- (iii) Requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under paragraph (h) of this section and then to remeasure to assess performance improvement after such intervention.

Measures group means a subset of six or more PQRS measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

Physician Quality Reporting System (PQRS) means the physician reporting system under section 1848(k) of the Act for the reporting by eligible professionals of data on quality measures and the incentive payment associated with this physician reporting system.

Performance rate means the percentage of a defined population who receives a particular process of care or achieve a particular outcome for a particular quality measure.

Qualified clinical data registry means a CMS-approved entity that has self-nominated and successfully completed a qualification process that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. A qualified clinical data registry must perform the following functions:

- (i) Submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its eligible professionals have satisfactorily participated in PQRS. A qualified clinical data registry must have in place mechanisms for the transparency of data elements and specifications, risk models, and measures.
- (ii) Submit to CMS, for purposes of demonstrating satisfactory participation, quality measures data on multiple payers, not just Medicare patients.
- (iii) Provide timely feedback, at least four times a year, on the measures at the individual participant level for which the qualified clinical data registry reports on the eligible professional's behalf for purposes of the individual eligible professional's satisfactory participation in the clinical quality data registry.
- (iv) Possess benchmarking capacity that measures the quality of care an eligible professional provides with other eligible professionals performing the same or similar functions.

Qualified registry means a medical registry or a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the PQRS qualification requirements specified by CMS for that program year. The registry may act as a data submission vendor, which has the requisite legal authority to provide PQRS data (as specified by CMS) on behalf of an eligible professional to CMS. If CMS

finds that a qualified registry submits grossly inaccurate data for reporting periods occurring in a particular year, CMS reserves the right to disqualify a registry for reporting periods occurring in the subsequent year.

Reporting rate means the percentage of patients that the eligible professional indicated a quality action was or was not performed divided by the total number of patients in the denominator of the measure.

(c) *Incentive payments.* For 2007 to 2014, with respect to covered professional services furnished during a reporting period by an eligible professional, an eligible professional (or in the case of a group practice under paragraph (i) of this section, a group practice) may receive an incentive if—

(1) There are any quality measures that have been established under the PQRS that are applicable to any such services furnished by such professional (or in the case of a group practice under paragraph (i) of this section, such group practice) for such reporting period; and

(2) If the eligible professional (or in the case of a group practice under paragraph (j) of this section, the group practice) satisfactorily submits (as determined under paragraph (g) of this section for the eligible professional and paragraph (i) of this section for the group practice) to the Secretary data on such quality measures in accordance with the PQRS for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also must be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act or, in the case of a group practice under paragraph (i) of this section, to the group practice) from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable quality percent (as specified in paragraph (c)(3) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (i) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (i)

of this section, by the group practice) during the reporting period.

(3) The applicable quality percent is as follows:

(i) For 2007 and 2008, 1.5 percent.

(ii) For 2009 and 2010, 2.0 percent.

(iii) For 2011, 1.0 percent.

(iv) For 2012, 2013, and 2014, 0.5 percent.

(4) For purposes of this paragraph (c)—

(i) The eligible professional's (or, in the case of a group practice under paragraph (i) of this section, the group practice's) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(ii) In the case of the eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(iii) Incentive payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the PQRS to eligible professionals in the group practice for meeting the criteria for satisfactory reporting for individual eligible professionals. For any program year in which the group practice (as identified by the TIN) is selected to participate in the PQRS group practice reporting option, the eligible professional cannot individually qualify for a PQRS incentive payment by meeting the requirements specified in paragraph (g) of this section.

(iv) Incentive payments earned by the eligible professional (or in the case of a group practice under paragraph (i) of this section, by the group practice) for a particular program year will be paid as a single consolidated payment to the TIN holder of record.

(5) The Secretary must treat an individual eligible professional, as identified by a unique TIN/NPI combination, as satisfactorily submitting data on quality measures (as determined under

paragraph (g) of this section), if the eligible professional is satisfactorily participating (as determined under paragraph (h) of this section), in a qualified clinical data registry.

(d) *Additional incentive payment.* Through 2014, if an eligible professional meets the requirements described in paragraph (d)(2) of this section, the applicable percent for such year, as described in paragraphs (c)(3)(iii) and (iv) of this section, must be increased by 0.5 percentage points.

(1) In order to qualify for the additional incentive payment described in paragraph (d) of this section, an eligible professional must meet all of the following requirements:

(i) Satisfactorily submits data on quality measures, or, for 2014, in lieu of satisfactory reporting, satisfactorily participates in a qualified clinical data registry for purposes of this section for the applicable incentive year.

(ii) Have such data submitted on their behalf through a Maintenance of Certification program that meets:

(A) The criteria for a registry (as specified by CMS); or

(B) An alternative form and manner determined appropriate by the Secretary.

(iii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(A) Participates in a maintenance of certification program for a year; and

(B) Successfully completes a qualified maintenance of certification program practice assessment for such year.

(2) In order for an eligible professional to receive the additional incentive payment, a Maintenance of Certification Program must submit to the Secretary, on behalf of the eligible professional, information—

(i) In a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of paragraph (d)(1)(iii) of this section, which may be in the form of a structural measure.

(ii) If requested by the Secretary, on the survey of patient experience with care.

(iii) As the Secretary may require, on the methods, measures, and data used

under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(e) *Payment adjustments.* For 2015 and subsequent years, with respect to covered professional services furnished by an eligible professional, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under section 1848(m)(3)(A) of the Act), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes for determining a payment based on such amount) must be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this paragraph (e).

(1) The applicable percent is as follows:

(i) For 2015, 98.5 percent.

(ii) For 2016 and each subsequent year, 98 percent.

(2) The Secretary must treat an individual eligible professional, as identified by a unique TIN/NPI combination, as satisfactorily submitting data on quality measures (as determined under paragraph (h) of this section), if the eligible professional is satisfactorily participating, in a qualified clinical data registry.

(f) *Use of appropriate and consensus-based quality measures.* For measures selected for inclusion in the PQRS quality measure set, CMS will use group practice measures determined appropriate by CMS and consensus-based quality measures that meet one of the following criteria:

(1) Be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act. In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by

a consensus organization identified by the Secretary.

(2) For each quality measure adopted by the Secretary under this paragraph, the Secretary ensures that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of quality measures applicable to services they furnish.

(g) *Use of quality measures for satisfactory participation in a qualified clinical data registry.* For measures selected for reporting to meet the criteria for satisfactory participation in a qualified clinical data registry, CMS will use measures selected by qualified clinical data registries based on parameters set by CMS.

(h) *Satisfactory reporting requirements for the incentive payments.* In order to qualify to earn a PQRS incentive payment for a particular program year, an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for satisfactory reporting specified by CMS under paragraph (h)(3) of (h)(5) of this section for such year by reporting on either individual PQRS quality measures or PQRS measures groups identified by CMS during a reporting period specified in paragraph (h)(1) of this section, using one of the reporting mechanisms specified in paragraph (h)(2) or (4) of this section, and using one of the reporting criteria specified in paragraph (h)(3) or (5) of this section.

(1) *Reporting periods.* For purposes of this paragraph, the reporting period is—

(i) The 12-month period from January 1 through December 31 of such program year.

(ii) A 6-month period from July 1 through December 31 of such program year.

(A) For 2011, such 6-month reporting period is not available for EHR-based reporting of individual PQRS quality measures.

(B) For 2012 and subsequent program years, such 6-month reporting period from July 1 through December 31 of such program year is only available for registry-based reporting of PQRS measures groups by eligible professionals.

(2) *Reporting mechanisms for individual eligible professionals.* An individual eligible professional who wishes to participate in the PQRS must report information on PQRS quality measures identified by CMS in one of the following manners:

(i) *Claims.* Reporting PQRS quality measures or PQRS measures groups to CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished during the applicable reporting period.

(A) If an eligible professional re-submits a Medicare Part B claim for re-processing, the eligible professional may not attach a G-code at that time for reporting on individual PQRS measures or measures groups.

(B) [Reserved]

(ii) *Registry.* Reporting PQRS quality measures or PQRS measures groups to a qualified registry in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry must submit information, as required by CMS, for covered professional services furnished by the eligible professional during the applicable reporting period to CMS on the eligible professional's behalf.

(iii) *Direct EHR product.* Reporting PQRS quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from a direct EHR product by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period.

(iv) *EHR data submission vendor.* Reporting PQRS quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from an EHR data submission vendor product by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period.

(v) Although an eligible professional may attempt to qualify for the PQRS incentive payment by reporting on both individual PQRS quality measures and measures groups, using more than one reporting mechanism (as specified

in paragraph (g)(2) of this section), or reporting for more than one reporting period, he or she will receive only one PQRS incentive payment per TIN/NPI combination for a program year.

(3) *Satisfactory reporting criteria for individual eligible professionals for the 2014 PQRS incentive.* An individual eligible professional who wishes to qualify for the 2014 PQRS incentive must report information on PQRS quality measures data in one of the following manners:

(i) *Via Claims.* For the 12-month 2014 PQRS incentive reporting period—

(A) Report at least 9 measures covering at least 3 National Quality Strategy domains, and report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies; or if less than 9 measures covering at least 3 National Quality Strategy domains apply to the eligible professional, report 1 to 8 measures covering 1 to 3 National Quality Strategy domains and report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. For an eligible professional who reports fewer than 9 measures covering at least 3 NQS domains via the claims-based reporting mechanism, the eligible professional would be subject to the Measures Applicability Validation process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures and/or covering additional National Quality Strategy domains. Measures with a 0 percent performance rate would not be counted.

(B) [Reserved]

(ii) *Via Qualified Registry.* (A) For the 12-month 2014 PQRS incentive reporting period—

(I) Report at least 9 measures covering at least 3 of the National Quality Strategy domains report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies; or, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1 to 8 measures covering 1 to 3 National Quality Strategy domains for which there is Medicare

patient data and report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. For an eligible professional who reports fewer than 9 measures covering at least 3 NQS domains via the qualified registry-based reporting mechanism, the eligible professional will be subject to the Measures Applicability Validation process, which would allow us to determine whether an eligible professional should have reported on additional measures and/or measures covering additional National Quality Strategy domains. Measures with a 0 percent performance rate would not be counted.

(2) Report at least 1 measures group and report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients. Measures with a 0 percent performance rate or measures groups containing a measure with a 0 percent performance rate will not be counted.

(B) For the 6-month 2014 PQRS incentive reporting period, report at least 1 measures group and report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.

(iii) *Via EHR Direct Product.* For the 12-month 2014 PQRS incentive reporting period, report 9 measures covering at least 3 of the National Quality Strategy domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data. An eligible professional must report on at least 1 measure for which there is Medicare patient data.

(iv) *Via EHR Data Submission Vendor.* For the 12-month 2014 PQRS incentive reporting period, report 9 measures covering at least 3 of the National Quality Strategy domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report

the measures for which there is Medicare patient data. An eligible professional must report on at least 1 measure for which there is Medicare patient data.

(4) *Reporting mechanisms for group practices.* With the exception of a group practice who wishes to participate in the PQRS using the certified survey vendor mechanism (as specified in paragraph (h)(4)(v) of this section), a group practice must report information on PQRS quality measures identified by CMS in one of the following reporting mechanisms:

(i) *Web interface.* For 2013 and subsequent years, reporting PQRS quality measures to CMS using a CMS web interface in the form and manner and by the deadline specified by CMS.

(ii) *Registry.* For 2013 and subsequent years, reporting on PQRS quality measures to a qualified registry in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry must submit information, as required by CMS, for covered professional services furnished by the eligible professional during the applicable reporting period to CMS on the eligible professional's behalf.

(iii) *Direct EHR product.* For 2014 and subsequent years, reporting PQRS quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from a direct EHR product by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period.

(iv) *EHR data submission vendor.* For 2014 and subsequent years, reporting PQRS quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from an EHR data submission vendor product by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period.

(v) *Certified survey vendors.* For 2014 and subsequent years, reporting CAHPS for PQRS survey measures to CMS using a vendor that is certified by CMS for a particular program year to transmit survey measures data to

CMS. Group practices that elect this reporting mechanism must select an additional group practice reporting mechanism in order to meet the criteria for satisfactory reporting for the incentive payments.

(vi) Although a group practice may attempt to qualify for the PQRS incentive payment by using more than one reporting mechanism (as specified in paragraph (g)(3) of this section), or reporting for more than one reporting period, the group practice will receive only one PQRS incentive payment for a program year.

(5) *Satisfactory reporting criteria for group practices for the 2014 PQRS incentive.* A group practice who wishes to qualify for the 2014 PQRS incentive must report information on PQRS quality measures identified by CMS in one of the following manners:

(i) *Via the GPRO web interface.* (A) For the 12-month 2014 PQRS incentive reporting period, for a group practice of 25 to 99 eligible professionals, report on all measures included in the web interface and populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.

(B) For the 12-month 2014 PQRS incentive reporting period, for a group practice of 100 or more eligible professionals, report on all measures included in the web interface and populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries. In addition, for the 12-month 2014 PQRS incentive reporting period, the group practice must report all CAHPS for PQRS survey measures via a CMS-certified survey vendor, and report at least 6 measures covering at least 2 of the National Quality Strategy domains using a qualified registry, direct EHR product, or EHR data submission vendor.

(ii) *Via Qualified Registry.* For the 12-month 2014 PQRS incentive reporting period, for a group practice of 2 or more eligible professionals, report at least 9 measures, covering at least 3 of the National Quality Strategy domains and report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies; or, if less than 9 measures covering at least 3 NQS domains apply to the group practice, then the group practice must report 1–8 measures for which there is Medicare patient data and report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. For a group practice who reports fewer than 9 measures covering at least 3 NQS domains via the qualified registry-based reporting mechanism, the group practice would be subject to the Measures Applicability Validation process, which would allow us to determine whether a group practice should have reported on additional measures and/or measures covering additional National Quality Strategy domains. Measures with a 0 percent performance rate would not be counted.

(iii) *Via EHR Direct Product.* For the 12-month 2014 PQRS incentive reporting period, for a group practice of 2 or more eligible professionals, report 9 measures covering at least 3 of the National Quality Strategy domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.

(iv) *Via EHR Data Submission Vendor.* For the 12-month 2014 PQRS incentive reporting period, for a group practice of 2 or more eligible professionals, report 9 measures covering at least 3 of the National Quality Strategy domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group prac-

tice must report on at least 1 measure for which there is Medicare patient data.

(v) *Via a Certified survey vendor, in addition to the GPRO web interface, qualified registry, direct EHR product, or EHR data submission vendor reporting mechanisms.* For the 12-month 2014 PQRS incentive reporting period, for a group practice of 25 or more eligible professionals, report all CAHPS for PQRS survey measures via a CMS-certified survey vendor, and report at least 6 measures covering at least 2 of the National Quality Strategy domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.

(i) *Satisfactory participation requirements for the incentive payments for individual eligible professionals.* To qualify for the 2014 PQRS incentive using a qualified clinical data registry, an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for satisfactory participation as specified under paragraph (i)(3) of this section by reporting on quality measures identified by a qualified clinical data registry during a reporting period specified in paragraph (i)(1) of this section, and using the reporting mechanism specified in paragraph (i)(2) of this section.

(1) *Reporting period.* For purposes of this paragraph, the reporting period is the 12-month period from January 1 through December 31.

(2) *Reporting Mechanism.* An individual eligible professional who wishes to meet the criteria for satisfactory participation in a qualified clinical data registry must use a qualified clinical data registry to report information on quality measures identified by the qualified clinical data registry.

(3) *Satisfactory participation criteria for individual eligible professionals for the 2014 PQRS incentive.* An individual eligible professional who wishes to qualify for the 2014 PQRS incentive through satisfactory participation in a qualified clinical data registry must report information on quality measures identified by the qualified clinical data registry in the following manner:

(i) For the 12-month 2014 PQRS incentive reporting period, report at

least 9 measures designated for reporting under a qualified clinical data registry covering at least 3 of the National Quality Strategy domains and report each measure for at least 50 percent of the eligible professional's patients. Of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure.

(ii) [Reserved]

(j) *Satisfactory reporting requirements for the payment adjustments.* In order to satisfy the requirements for the PQRS payment adjustment for a particular program year, an individual eligible professional, as identified by a unique TIN/NPI combination, or a group practice must meet the criteria for satisfactory reporting specified by CMS for such year by reporting on either individual PQRS measures or PQRS measures groups identified by CMS during a reporting period specified in paragraph (j)(1) of this section, using one of the reporting mechanisms specified in paragraph (j)(2) or (4) of this section, and using one of the reporting criteria specified in section (j)(3) or (5) of this section.

(1) For purposes of this paragraph (j), the reporting period for the payment adjustment, with respect to a payment adjustment year, is the 12-month period from January 1 through December 31 that falls 2 years prior to the year in which the payment adjustment is applied.

(i) For the 2015 and 2016 PQRS payment adjustments only, an alternative 6-month reporting period, from July 1–December 31 that fall 2 years prior to the year in which the payment adjustment is applied, is also available.

(ii) [Reserved]

(2) *Reporting mechanisms for individual eligible professionals.* An individual eligible professional participating in the PQRS must report information on PQRS quality measures identified by CMS in one of the following manners:

(i) *Claims.* Reporting PQRS quality measures or PQRS measures groups to CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished during the applicable reporting period.

(A) If an eligible professional re-submits a Medicare Part B claim for re-processing, the eligible professional may not attach a G-code at that time for reporting on individual PQRS measures or measures groups.

(B) [Reserved]

(ii) *Registry.* Reporting PQRS quality measures or PQRS measures groups to a qualified registry in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry must submit information, as required by CMS, for covered professional services furnished by the eligible professional during the applicable reporting period to CMS on the eligible professional's behalf.

(iii) *Direct EHR product.* Reporting PQRS quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from a direct EHR product by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period.

(iv) *EHR data submission vendor.* Reporting PQRS quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from an EHR data submission vendor product by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period.

(v) *Administrative claims.* For 2015, reporting data on PQRS quality measures via administrative claims during the applicable reporting period. Eligible professionals that are administrative claims reporters must meet the following requirement for the payment adjustment:

(A) Elect to participate in the PQRS using the administrative claims reporting option.

(B) Reporting Medicare Part B claims data for CMS to determine whether the eligible professional has performed services applicable to certain individual PQRS quality measures.

(3) *Satisfactory reporting criteria for individual eligible professionals for the 2016 PQRS payment adjustment.* An individual eligible professional who wishes

to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment must report information on PQRS quality measures identified by CMS in one of the following manners:

(i) *Via Claims.* (A) For the 12-month 2016 PQRS payment adjustment reporting period—

(1)(i) Report at least 9 measures covering at least 3 National Quality Strategy domains and report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies; or if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 National Quality Strategy domains, and report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. For an eligible professional who reports fewer than 9 measures covering at least 3 NQS domains via the claims-based reporting mechanism, the eligible professional would be subject to the Measures Applicability Validation process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures and/or covering additional National Quality Strategy domains; or

(ii) Report at least 3 measures covering at least 1 NQS domain, or, if less than 3 measures covering at least 1 NQS domain apply to the eligible professional, report 1–2 measures covering at least 1 NQS domain; and report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.

(2) Measures with a 0 percent performance rate would not be counted.

(ii) *Via Qualified Registry.* (A) For the 12-month 2016 PQRS payment adjustment reporting period—

(1)(i) Report at least 9 measures covering at least 3 of the National Quality Strategy domains; or if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1 to 8 measures covering 1 to 3 National Quality Strategy domains for which there is Medicare patient data, and report each measure for

at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. For an eligible professional who reports fewer than 9 measures covering at least 3 NQS domains via the qualified registry-based reporting mechanism, the eligible professional would be subject to the Measures Applicability Validation process, which would allow us to determine whether an eligible professional should have reported on additional measures and/or measures covering additional National Quality Strategy domains; or

(ii) Report at least 3 measures covering at least 1 of the NQS domains; or if less than 3 measures covering at least 1 NQS domain apply to the eligible professional, report 1 to 2 measures covering 1 National Quality Strategy domain for which there is Medicare patient data, and report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. For an eligible professional who reports fewer than 3 measures covering 1 NQS domain via the registry-based reporting mechanism, the eligible professional would be subject to the Measures Applicability Validation process, which would allow us to determine whether an eligible professional should have reported on additional measures; or

(iii) Report at least 1 measures group and report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients.

(2) Measures with a 0 percent performance rate or measures groups containing a measure with a 0 percent performance rate will not be counted.

(B) For the 6-month 2016 PQRS payment adjustment reporting period—

(1) Report at least 1 measures group and report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.

(iii) *Via EHR Direct Product.* For the 12-month 2016 PQRS payment adjustment reporting period, report 9 measures covering at least 3 of the National

Quality Strategy domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data. An eligible professional must report on at least 1 measure for which there is Medicare patient data.

(iv) *Via EHR Data Submission Vendor.* For the 12-month 2016 PQRS payment adjustment reporting period, report 9 measures covering at least 3 of the National Quality Strategy domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data. An eligible professional must report on at least 1 measure for which there is Medicare patient data.

(4) *Satisfactory reporting criteria for individual eligible professionals for the 2017 PQRS payment adjustment.* An individual eligible professional who wishes to meet the criteria for satisfactory reporting for the 2017 PQRS payment adjustment must report information on PQRS quality measures identified by CMS in one of the following manners:

(i) *Via claims.* (A) For the 12-month 2017 PQRS payment adjustment reporting period—

(1)(i) Report at least 9 measures, covering at least 3 of the NQS domains and report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the 9 measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional must report on at least 1 measure contained in the cross-cutting measure set specified by CMS. If less than 9 measures apply to the eligible professional, report up to 8 measures and report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

(ii) [Reserved]

(ii) *Via qualified registry.* (A) For the 12-month 2017 PQRS payment adjustment reporting period—

(1)(i) Report at least 9 measures, covering at least 3 of the NQS domains and report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the 9 measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional must report on at least 1 measure contained in the cross-cutting measure set specified by CMS. If less than 9 measures apply to the eligible professional, report up to 8 measures and report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies.

(ii) Report at least 1 measures group and report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients.

(2) Measures with a 0 percent performance rate or measures groups containing a measure with a 0 percent performance rate will not be counted.

(iii) *Via EHR direct product.* For the 12-month 2017 PQRS payment adjustment reporting period, report 9 measures covering at least 3 of the NQS domains. If an eligible professional's direct EHR product does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data. An eligible professional must report on at least 1 measure for which there is Medicare patient data.

(iv) *Via EHR Data Submission Vendor.* For the 12-month 2017 PQRS payment adjustment reporting period, report 9 measures covering at least 3 of the NQS domains. If an eligible professional's EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data. An eligible professional must report on at least 1 measure for which there is Medicare patient data.

(5) *Reporting mechanisms for group practices.* With the exception of a group practice who wishes to participate in the PQRS using the certified survey vendor mechanism, a group practice participating in the PQRS must report information on PQRS quality measures identified by CMS in one of the following reporting mechanisms:

(i) *Web interface.* For the 2015 payment adjustment and subsequent payment adjustments, reporting PQRS quality measures to CMS using a CMS web interface in the form and manner and by the deadline specified by CMS.

(ii) *Registry.* For the 2015 subsequent adjustment and subsequent payment adjustments, reporting on PQRS quality measures to a qualified registry in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the applicable reporting period to CMS on the eligible professional's behalf.

(iii) *Direct EHR product.* For the 2016 subsequent adjustment and subsequent payment adjustments, reporting PQRS quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from a direct EHR product by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period.

(iv) *EHR data submission vendor.* For the 2016 subsequent adjustment and subsequent payment adjustments, reporting PQRS quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from an EHR data submission vendor product by the deadline specified by CMS for covered professional services furnished by the group practice during the applicable reporting period.

(v) *Administrative claims.* For 2015, reporting data on PQRS quality measures via administrative claims during the applicable reporting period. Group practices that are administrative claims reporters must meet the following requirement for the payment adjustment:

(A) Elect to participate in the PQRS using the administrative claims reporting option.

(B) Reporting Medicare Part B claims data for CMS to determine whether the group practice has performed services applicable to certain individual PQRS quality measures.

(vi) *Certified Survey Vendors.* For 2016 and subsequent years, reporting CAHPS for PQRS survey measures to CMS using a vendor that is certified by CMS for a particular program year to transmit survey measures data to CMS. Group practices that elect this reporting mechanism must select an additional group practice reporting mechanism in order to meet the criteria for satisfactory reporting for the payment adjustment.

(6) *Satisfactory reporting criteria for group practices for the 2016 PQRS payment adjustment.* A group practice who wishes to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment must report information on PQRS quality measures identified by CMS in one of the following manners:

(i) *Via the GPRO web interface.* (A) For the 12-month 2016 PQRS payment adjustment reporting period, for a group practice of 25 to 99 eligible professionals, report on all measures included in the web interface and populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.

(B) For the 12-month 2016 PQRS payment adjustment reporting period, for a group practice of 100 or more eligible professionals, report on all measures included in the Web interface and populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries. In addition, the group practice must also report all CAHPS for PQRS survey measures via certified survey vendor.

(ii) *Via Qualified Registry.* (A) For the 12-month 2016 PQRS payment adjustment reporting period, for a group practice of 2 or more eligible professionals—

(1) Report at least 9 measures, covering at least 3 of the National Quality Strategy domains and report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies; or If less than 9 measures covering at least 3 NQS domains apply to the eligible professional, then the group practices must report 1-8 measures for which there is Medicare patient data and report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. For a group practice who reports fewer than 9 measures covering at least 3 NQS domains via the registry-based reporting mechanism, the group practice would be subject to the Measures Applicability Validation process, which would allow us to determine whether a group practice should have reported on additional measures. Measures with a 0 percent performance rate would not be counted; or

(2) Report at least 3 measures, covering at least 1 of the National Quality Strategy domains and report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies; or if less than 3 measures covering at least 1 NQS domain apply to the group practice, then the group practice must report 1-2 measures for which there is Medicare patient data and report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. For a group practice who reports fewer than 3 measures covering at least 1 NQS domain via the registry-based reporting mechanism, the group practice would be subject to the Measures Applicability Validation process, which would allow us to determine whether a group practice should have reported on additional measures. Measures with a 0 percent performance rate would not be counted.

(iii) *Via EHR Direct Product.* For a group practice of 2 or more eligible professionals, for the 12-month 2016 PQRS payment adjustment reporting period, report 9 measures covering at least 3 of the National Quality Strategy domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.

(iv) *Via EHR Data Submission Vendor.* For a group practice of 2 or more eligible professionals, for the 12-month 2016 PQRS payment adjustment reporting period, report 9 measures covering at least 3 of the National Quality Strategy domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.

(v) *Via a Certified survey vendor, in addition to the GPRO Web interface, qualified registry, direct EHR product, or EHR data submission vendor reporting mechanisms.* For a group practice of 25 or more eligible professionals, for the 12-month 2016 PQRS payment adjustment reporting period, report all CAHPS for PQRS survey measures via a CMS-certified survey vendor and report at least 6 measures covering at least 2 of the National Quality Strategy domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO Web interface.

(7) *Satisfactory reporting criteria for group practices for the 2017 PQRS payment adjustment.* A group practice who wishes to meet the criteria for satisfactory reporting for the 2017 PQRS payment adjustment must report information on PQRS quality measures identified by CMS in one of the following manners:

(i) *Via the GPRO web interface.* For the 12-month 2017 PQRS payment adjustment reporting period, for a group

practice of 25 to 99 eligible professionals, report on all measures included in the web interface and populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then report on 100 percent of assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.

(ii) *Via Qualified Registry.* For a group practice of 2 to 99 eligible professionals, for the 12-month 2017 PQRS payment adjustment reporting period, report at least 9 measures, covering at least 3 of the NQS domains and report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies; or if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, then the group practice must report up to 8 measures for which there is Medicare patient data and report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if any eligible professional in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report on at least 1 measure contained in the cross-cutting measure set specified by CMS. Measures with a 0 percent performance rate would not be counted; or

(iii) *Via EHR Direct Product.* For a group practice of 2 to 99 eligible professionals, for the 12-month 2017 PQRS payment adjustment reporting period, report 9 measures covering at least 3 of the NQS domains. If a group practice's direct EHR product does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.

(iv) *Via EHR Data Submission Vendor.* For a group practice of 2 to 99 eligible professionals, for the 12-month 2017

PQRS payment adjustment reporting period, report 9 measures covering at least 3 of the NQS domains. If a group practice's EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.

(v) *Via a Certified Survey Vendor in addition to a Qualified Registry.* For a group practice of 2 or more eligible professionals, for the 12-month 2017 PQRS payment adjustment reporting period, report all CAHPS for PQRS survey measures via a CMS-certified survey vendor and report at least 6 additional measures covering at least 2 of the NQS domains using a qualified registry. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any eligible professional in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report on at least 1 measure in the cross-cutting measure set specified by CMS.

(vi) *Via a Certified Survey Vendor in addition a Direct EHR Product or EHR Data Submission Vendor.* For a group practice of 2 or more eligible professionals, for the 12-month 2017 PQRS payment adjustment reporting period, report all CAHPS for PQRS survey measures via a CMS-certified survey vendor and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the direct EHR product that is CEHRT or EHR data submission vendor product that is CEHRT. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, the group practice must report on at least 1 measure for which there is Medicare patient data.

(vii) *Via a Certified Survey Vendor in addition to the GPRO Web interface.* (A)

For a group practice of 25 or more eligible professionals, for the 12-month 2017 PQRS payment adjustment reporting period, report all CAHPS for PQRS survey measures via a CMS-certified survey vendor and report on all measures included in the GPRO web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice would report on 100 percent of assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.

(B) [Reserved]

(k) *Satisfactory participation requirements for the payment adjustments for individual eligible professionals.* In order to satisfy the requirements for the PQRS payment adjustment for a particular program year through participation in a qualified clinical data registry, an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for satisfactory participation as specified in paragraph (k)(3) for such year, by reporting on quality measures identified by a qualified clinical data registry during a reporting period specified in paragraph (k)(1) of this section, using the reporting mechanism specified in paragraph (k)(2) of this section.

(1) Reporting period. For purposes of this paragraph, the reporting period is—

(i) The 12-month period from January 1 through December 31 that falls 2 years prior to the year in which the payment adjustment is applied.

(ii) [Reserved]

(2) *Reporting Mechanism.* An individual eligible professional who wishes to meet the criteria for satisfactory participation in a qualified clinical data registry must use the qualified clinical data registry to report information on quality measures identified by the qualified clinical data registry.

(3) Satisfactory participation criteria for individual eligible professionals for the 2016 PQRS payment adjustment. An individual eligible professional who wishes to meet the criteria for satisfac-

tory participation in a qualified clinical data registry for the 2016 PQRS payment adjustment must report information on quality measures identified by the qualified clinical data registry in one of the following manners:

(i) For the 12-month 2016 PQRS payment adjustment reporting period—

(A) Report at least 9 measures available for reporting under a qualified clinical data registry covering at least 3 of the National Quality Strategy domains and report each measure for at least 50 percent of the eligible professional's patients; or

(B) Report at least 3 measures available for reporting under a qualified clinical data registry covering at least 1 of the National Quality Strategy domains and report each measure for at least 50 percent of the eligible professional's patients.

(4) *Satisfactory participation criteria for individual eligible professionals for the 2017 PQRS payment adjustment.* An individual eligible professional who wishes to meet the criteria for satisfactory participation in a QCDR for the 2017 PQRS payment adjustment must report information on quality measures identified by the QCDR in one of the following manner:

(i) For the 12-month 2017 PQRS payment adjustment reporting period, report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, and report each measure for at least 50 percent of the eligible professional's patients. Of these measures, report on at least 2 outcome measures, or, if 2 outcomes measures are not available, report on at least 2 outcome measures and at least 1 of the following types of measures—resource use, patient experience of care, efficiency/appropriate use or patient safety.

(ii) [Reserved]

(1) *Requirements for group practices.* Under the PQRS, a group practice must meet all of the following requirements:

(1) Meet the participation requirements specified by CMS for the PQRS group practice reporting option.

(2) Report measures in the form and manner specified by CMS.

(3) Meet other requirements for satisfactory reporting specified by CMS.

(4) Meet other requirements for satisfactory reporting specified by CMS.

(5) Meet participation requirements.

(i) If an eligible professional, as identified by an individual NPI, has reassigned his or her Medicare billing rights to a group practice (as identified by the TIN) selected to participate in the PQRS group practice reporting option for a program year, then for that program year the eligible professional must participate in the PQRS via the group practice reporting option.

(ii) If, for the program year, the eligible professional participates in the PQRS as part of a group practice (as identified by the TIN) that is not selected to participate in the PQRS group practice reporting option for that program year, then the eligible professional may individually participate and qualify for a PQRS incentive by meeting the requirements specified in paragraph (g) of this section under that TIN.

(m) *Informal review.* Eligible professionals or group practices may seek an informal review of the determination that an eligible professional or group practices did not satisfactorily submit data on quality measures under the PQRS, or, for individual eligible professionals, in lieu of satisfactory reporting, did not satisfactorily participate in a qualified clinical data registry.

(1) To request an informal review for reporting periods that occur prior to 2014, an eligible professional or group practice must submit a request to CMS within 90 days of the release of the feedback reports. To request an informal review for reporting periods that occur in 2014 and subsequent years, an eligible professional or group practice must submit a request to CMS within 60 days of the release of the feedback reports. The request must be submitted in writing and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(2) CMS will provide a written response within 90 days of the receipt of the original request.

(i) All decisions based on the informal review will be final.

(ii) There will be no further review or appeal.

(3) If, during the informal review process, CMS finds errors in data that was submitted by a third-party vendor on behalf of an eligible professional or group practice using either the qualified registry, EHR data submission vendor, or QCDR reporting mechanisms, CMS may allow for the resubmission of data to correct these errors.

(i) CMS will not allow resubmission of data submitted via claims, direct EHR, and the GPRO web interface reporting mechanisms.

(ii) CMS will only allow resubmission of data that was already previously submitted to CMS.

(iii) CMS will only accept data that was previously submitted for the reporting periods for which the corresponding informal review period applies.

(n) *Limitations on review.* Except as specified in paragraph (i) of this section, there is no administrative or judicial review under section 1869 or 1879 of the Act, or otherwise of—

(1) The determination of measures applicable to services furnished by eligible professionals under the PQRS;

(2) The determination of satisfactory reporting; and

(3) The determination of any Physician Quality Reporting System incentive payment and the PQRS payment adjustment.

(o) *Public reporting of an eligible professional's or group practice's PQRS data.* For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) who satisfactorily submitted PQRS quality measures.

[78 FR 74812, Dec. 10, 2013, as amended at 79 FR 68003, Nov. 13, 2014]

§ 414.92 Electronic Prescribing Incentive Program.

(a) *Basis and scope.* This section implements the following provisions of the Act:

(1) Section 1848(a)—Payment Based on Fee Schedule.

(2) Section 1848(m)—Incentive Payments for Quality Reporting.

(b) *Definitions.* As used in this section, unless otherwise indicated—